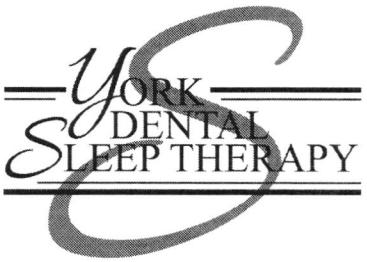

Medical History

Name:_____ DOB:_____

Address:_____

Phone number:_____ Email:_____

Medical Insurance:_____

Family Doctor:_____ Last visit within 6mos? Y N

Why are you seeing us today?_____

_____

Sex:

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks ☐
☐	☐	Are you nursing?

Please answer the following:

Y	N		
☐	☐	Do you smoke or use tobacco?	Height:
For Office Use Only			
BP		Heart Rate:	Weight:

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Actonel/Boniva/Fosamax
☐	☐	Alcohol/Drug Abuse
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Artificial Bones/Joints/Valves
☐	☐	Asthma
☐	☐	Autoimmune Issues
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Dye/SLS Sensitivity
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Food Allergies
☐	☐	Frequent Headaches
☐	☐	HIV+ AIDS
☐	☐	Heart Attack
☐	☐	Heart Murmur

Y	N	Conditions
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Herpes/Fever Blisters
☐	☐	High Blood Pressure
☐	☐	High Cholesterol
☐	☐	Hospitalized For Any Reason
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Osteoporosis
☐	☐	Pace Maker
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sinus Problems
☐	☐	Sleep Apnea
☐	☐	Snoring

Y	N	Conditions
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

YORK DENTAL SLEEP THERAPY

Gordon M. Bell, DDS, FICOI, FAGD
DABDSM, DABCDSM, DACSDD

STOP BANG

Screening for: Obstructive Sleep Apnea

Name: _____

STOP

S (snore)	Have you been told that you snore?	Yes	No
T (tired)	Are you often tired during the day?	Yes	No
O (obstruction)	Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep?	Yes	No
P (pressure)	Do you have high blood pressure or on medication to control high blood pressure?	Yes	No

If you answered YES to two or more questions on the STOP portion you are at risk for Obstructive Sleep Apnea. It is recommended that you contact your primary care provider to discuss a possible sleep disorder.

To find out if you are at moderate to severe risk of Obstructive Sleep Apnea, complete BANG questions below.

B (BMI)	Is your body mass index greater than 28?	Yes	No
A (age)	Are you 50 years old or older?	Yes	No
N (neck)	Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches?	Yes	No
G (gender)	Are you a male?	Yes	No
	Are you aware of clenching and grinding?	**YES**	**NO**

The more questions you answer YES to on the BANG portion, the greater your risk of having moderate to severe Obstructive Sleep Apnea.

Name: _____

Tell us about your sleep habits

1.) Do you go to bed the same time every night? Y or N

2.) Do you follow a nighttime ritual? Y or N

If yes, please describe _____

_____

3.) Is your bedroom cool, dark and quiet? Y or N

4.) Is there a T.V. or other electronic devices in your bedroom? Y or N

If yes, please describe _____

_____

5.) Do you stop using your electronic devices 1 hour before bedtime? Y or N

6.) Do you use any blue light minimizing features on your electronic devices? (i.e. Night shift, blue shade, etc.) Y or N

7.) Do your pets sleep in bed with you? Y or N

8.) Do you work night/alternate shift? Y or N

If yes, please describe _____

_____

9.) Do you nap during the day? Y or N

If yes, how long is your nap _____

10.) Within a couple of hours before bedtime, do you do any of the following?

Caffeinated beverages Y or N

Alcoholic beverages Y or N

Large meals Y or N

Smoking/Vaping Y or N

11.) If you get up in the middle of the night, do you engage in any activity? (i.e. computer use, smoke a cigarette, have a beverage, laundry etc.) Y or N

If yes, please describe _____

_____

12.) Do you take any sleep aides to help you sleep? Y or N

If yes, please list _____

Name:_____

Sleep Quality Questionnaire

1.) How long does it take you to fall asleep? _____

2.) If you then wake up one or more times during the night, how long are you awake in total? (add up all the times you are awake) _____

3.) If your final wake up time occurs before you intend to wake up, how much earlier is this?
_____

4.) How many nights a week do you have a problem with your sleep?_____

5.) How would you rate your sleep quality?
Very good Good Average Poor Very poor

6.) Has your poor sleep affected your mood, energy or relationships?
Not at all A little Somewhat Much Very much

7.) Has your poor sleep affected your concentration, productivity or ability to stay awake?
Not at all A little Somewhat Much Very much

8.) Has your poor sleep troubled you in general?
Not at all A little Somewhat Much Very much

9.) How long have you had a problem with your sleep?_____

How's your nasal breathing

Do you breathe easily through your nose? Y or N
Are you nasally congested during the day? Y or N
Is your nasal congestion worse at night? Y or N
Do you experience nasal allergies resulting in nasal blockage? Y or N
Do you take medications for allergies? Y or N
If so, do you use pills or nasal sprays _____
Do you breathe through your mouth? Y or N
Do you wake with a sore throat or a dry mouth? Y or N

When was the last time you had blood work done?_____
Have you had your Thyroid levels checked recently? Y or N
Have you had your Vitamin D levels checked by your physician? Y or N

PATIENT'S NAME _____

EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation:

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Date _____

SITUATION

Sitting and reading	_____
Watching Television	_____
Sitting inactive in a public place (i.e. theater)	_____
As a car passenger for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopping for a few minutes in traffic	_____
TOTAL SCORE	_____

A score of 6 or greater indicates the possibility of sleep disordered breathing

THORNTON SNORING SCALE

Snoring has a significant effect on the quality of life for many people. Snoring can affect the person snoring and those around him/her., both physically and emotionally. Use the following scale to choose the most appropriate number for each situation.

0 = Never
1 = Infrequently (1 night per week)
2 = Frequently (2-3 nights per week)
3 = Most of the time (4 or more nights per week)

My snoring affects my relationship with my partner	_____
My snoring causes my partner to be irritable or tired	_____
My snoring requires us to sleep in separate rooms	_____
My snoring is loud	_____
My snoring affects people when I am sleeping away from home (i.e. hotel, camping, etc.)	_____
TOTAL SCORE	_____

A score of 5 or greater indicates your snoring may be significantly affecting your quality of life